CALIFORNIA PCIP Pre-Existing Condition Insurance Plan

Pre-Existing Condition Form

This form must be completely filled out and signed by a Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner who is licensed to practice.

I. Patient's Information	
Patient's First & Last Name:***(Required)***	Patient's Condition ***(Required)***

II. Health Care Provider's Information		
Health Care Provider's First & Last Name:	License Number:***(Required)***	
Address (Number, Street, Ste. #):	City:	Zip Code:
Telephone Number:	Fax Number:	

The patient identified on this form has or had, the medical condition, disability, or illness listed above.

I declare that the information provided on this form is true and correct to the best of my knowledge.

➡ _____

Licensed Health Care Provider's Signature ***(Required)***

_____

Health Care Provider Category

_____

Date Signed***(Required)***